DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-04

2. STATE: VIRGINIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JULY 5, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ -0-
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
N/A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Remove Attachment 4.19B,
Supplement 1, pp1-6
(TN. No. 97-08)

10. SUBJECT OF AMENDMENT:
Repeal Obstetric/Pediatric Fees

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary, Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Dennis Smith

14. TITLE: Director

15. DATE SUBMITTED:

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Attn:Reg. Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 7-5-00

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL: Claudette V. Campbell

21. TYPED NAME: CLAUDETTE V. CAMPBELL

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back